



Ghana

Peer Educators Increase Knowledge of HIV/AIDS Among Youth

CEDPA tested both structured and unstructured peer educators models in Ghana to determine which was more effective in reaching youth. Although results differed, both demonstrated that condom use and HIV/AIDS messages were effective in increasing accurate knowledge among youth, but that a gap remained between knowledge and practice.

Overview

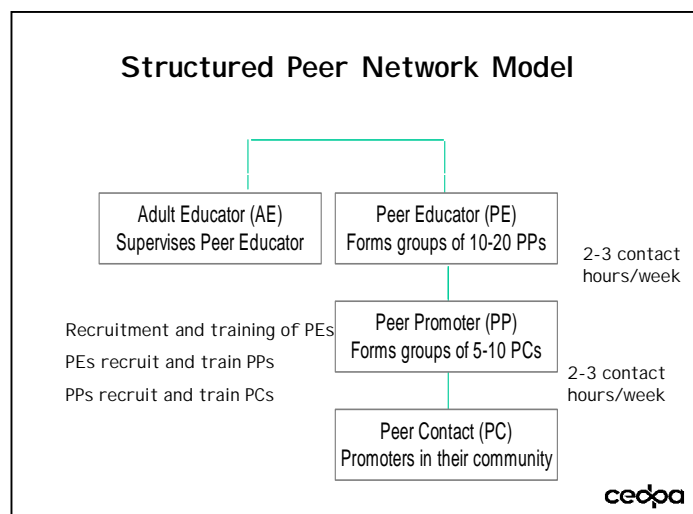
This project was developed to bridge the knowledge-practice gap in sexual and reproductive health (SRH) and achieve behavioral change among youth in Ghana. Two peer education models — one structured and formalized and the other unstructured and informal — to reach youth were tested.

Structured Peer Network Model

The Structured Model is similar to a pyramid scheme in that each peer educator formed a group of 10 to 20 youth whose role was to act as peer promoters. The peer educators and peer promoters met regularly for two to three hours weekly using a prescribed set of materials to study. Benchmarks systematically examined a series of reproductive health and family planning topics through discussions, role-plays, drama, games, debates, and various types of incentives. In the next stage, the 10 to 20 peer promoters formed youth groups of five to 10 new members called peer contacts. These groups also set aside one day a week to discuss the issues learned from the peer promoters, who in turn served as facilitators to their groups. Participants were recruited through community and religious leaders, friends, referrals, and personal contacts.

Unstructured Peer Network Model

The Unstructured Model also used peer educators to educate young people on SRH issues. However, in this model, the youth trained as volunteer peer educators discussed SRH issues with their friends informally. Participants met in the afternoon for 30 to 40 minutes,



15 to 20 times a month, but the meeting did not involve the same group format as in the Structured Model. Due to this loose structure and a lack of structured recruitment, group formation was uncommon and existing organizations were often utilized.

Research Study Findings

A research study was undertaken to determine the results. The study included surveys with 871 peer educators and promoters, along with focus group discussions, in-depth interviews, and observations with peer educators and community/opinion leaders.

- The Structured Model was more successful at reaching youth and improving their knowledge in the area of reproductive health than the Unstructured Model. However, the strongest point of the Unstruc-

tured Model was its inherent flexibility. Educators and promoters were free to use their own recruitment and education strategies. The facilitators largely controlled meeting times and the duration of discussions. They could choose either to contact individuals or work in groups.

- The Unstructured Model was too loosely defined to achieve results. Although the peer education program covered many settlements, the data did not demonstrate that many youth actually benefited from program activities. However, as there was no systematic method for recruiting such people (as indicated by most respondents), there was also no systematic process for identifying people who had benefited from programs. Some contacts were with large groups and therefore members were anonymous.
- Respondents reported using four main contraceptive methods — abstinence, condoms, rhythm method, and withdrawal — with abstinence the most cited method; less than a third of the males and females were using abstinence. The other methods were used less frequently. Long-term methods such as injectables were rarely used. Education level did not have a major influence on method choice, but religion did.
- In both models, the most common discussion topics were sexually-transmitted infections, HIV/AIDS, and teenage pregnancy. In the Structured Model, respondents also spoke of childhood diseases. Under the Unstructured Model, family planning methods was a common discussion topic.
- In the Unstructured Model, the survey team found inconsistent and often incomplete knowledge of condom use. For example, only about half of the females surveyed knew how to check the condom's expiration date and less than one-quarter of the respondents with junior and senior secondary school education agreed that condoms could be used to prevent HIV. The top two reasons stated for lack of knowledge on condom use were the lack of a penis model for demonstration and that the facilitator and members were too shy to conduct the demonstration.
- Many people had misconceptions about HIV/AIDS, specifically in terms of people living with HIV/AIDS (PLWHA). While the majority of males and females

indicated without hesitation that AIDS existed and some knew PLWHA in their communities, attitudes were generally negative towards them. Respondents believed that PLWHA were bad people who deserved the disease. In the Unstructured Model, even though the bulk of the respondents showed a positive attitude towards PLWHA, 39 percent of the males and 27 percent of the females still demonstrated poor or very poor attitudes towards PLWHA. These attitudes were particularly high among the few respondents aged 15-19 years and those with only junior secondary school education.

- About five percent of the males and seven percent of the females thought they did not need to do anything to prevent HIV/AIDS infection. One-third of females with no education and about a quarter of males with above secondary education held this view. Clearly, educational campaigns need to address this attitude.

Future Recommendations

- Non-governmental organizations (NGOs) should adopt the more structured peer educator model, but some remuneration should be given to both peer educators and promoters. In-service training should be provided for peer educators and peer promoters.
- Peer promoters should have a senior secondary education, since those without formal education or less than secondary school often lacked the confidence to form their own groups. Less-educated peer promoters need to receive extra training in communication skills and self-confidence.
- Since parents, teachers, and church leaders rarely teach SRH to youth, NGOs should increase advocacy efforts to promote themselves as credible alternatives and conduits to supplement SRH education in the schools.
- To meet its ultimate objective — to train a crop of people who assist others to change their SRH behavior — a follow-up intervention should investigate what methods will make people change their SRH behavior to a less risky, more life-affirming state.

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